CSHS Increased Medical Home Capacity – Fact Sheet

More funds will improve medical home capacity in additional medical practices, train more physicians, and provide more resource materials to expand care coordination for CSHCN in medical homes.

Objective

To promote a comprehensive, coordinated system of care for Children with Special Health Care Needs (CSHCN) in the Medical Home (MH).

Performance Indicators

1. # MHs trained in care coordination (CC)
2. # practices receiving resource materials
3. # residents trained in available resources

Narrative

The mission of CSHS is to assure that CSHCN in LA have access to healthcare services to minimize disabilities and maximize their ability to enjoy an independent life. CSHS has done this by providing direct subspecialty clinical services with CC in all 9 regions of the state. Newer initiatives focus on healthcare reform efforts, increasing capacity of MH to provide CC, and improving efficiency of CC within public health (PH) programs. These activities focus on infrastructure building and population based services, in accordance with MCH Title V block grant guidelines. CSHS has received recognition from Maternal and Child Health Bureau (MCHB) for its newer initiatives in its most recent grant review.

Specific activities include:

1. Training of LSU and Tulane pediatric and family practice residents in MH concepts and CC. Physicians lack knowledge of community and PH resources. CSHS provides incentives and training to academic practices willing to designate a CC within the practice. Residents learn to identify CSHCN within the practice and refer to appropriate

resources. CSHS has proven success with this model which was presented at the Louisiana Healthcare Quality Forum (LHCQF) MH Summit and is submitted for publication.

2. CSHS is performing a 5 year Needs Assessment for the Title V grant which includes an assessment of MH capacity in pediatric and family medicine practices statewide. CSHS will use information gained to provide region specific resource information for practices to improve their MH capacity, and to identify other training needs.
3. CSHS is forming a stakeholder group of representatives from agencies serving CSHCN to improve coordination of resources between programs. CSHS is surveying staff of the Office for Citizens with Developmental Disabilities (OCDD), DSS, Families Helping Families, School Based Health Clinics, and CSHS clinics to determine knowledge and referral patterns for CC among programs and to help determine CSHS long range goals. This will be used to improve collaboration among programs.
4. CSHS has piloted a new expanded CC program in CSHS clinics that focuses on youth in transition. This will be expanded statewide.
5. CSHS is helping to develop and pilot a master patient database for PH programs (the DHH-DSS Data Integration Project) to foster a single point of entry into PH programs for families. This will complement activities of the stakeholder group to improve efficiencies.
6. CSHS participates on the Advisory Board of the LHCQF, the CSHCN working group of the American Academy of Pediatrics (AAP), and administration's "Workgroup 5" to help address needs of CSHCN in LA's Healthcare Reform plan.

It is anticipated that all of the above activities will complement CSHS direct clinic activities (see APR) which improve access to subspecialty care in underserved areas. Direct CSHS services are decreased when CSHCN successfully access services in the private sector. CSHS is increasing the capacity of primary care practices to become MHs by providing training, support and incentives to pediatricians and family practice physicians. Research shows that when CSHCN are linked to a MH and receive CC services, these expenses are reduced, mostly by decreasing ER visits and hospitalizations through preventive care.

- Better Health
    - Improving MH capacity and improving CC for CSHCN by:
        - Providing incentives and training to academic and family practice clinics to provide CC for CSHCN and to meet National Committee for Quality Assurance (NCQA) MH criteria;
        - Training LSU and Tulane pediatric residents in MH concepts for use in their future practices
        - Collaborating with OCDD in the Operation House Call program to train pediatric residents at Tulane and LSU Medical Schools in the family-centered care concept
    - Building infrastructure for comprehensive care within the MH by participating in LHCQF and Medicaid initiatives

- Safe and Thriving Children and Families

- Linking families to a coordinated system of care by participating in the DHH-DSS Data Integration Project to create a master patient database to foster a single point of entry into programs that serve CSHCN
- Providing services to YSHCN to assist with transition to adult healthcare, work and independence in CSHS clinics
- Providing region-specific information to pediatric and family practice clinics on community-based resources, family support organizations and PH resources
- Addressing training needs of private providers identified by the CSHS Needs Assessment
- Forming a stakeholder group of agencies that serve CSHCN to improve coordination, communication and collaboration

- Youth Education
  - Working with schools in Department of Education and private school systems in identification and coordination of services to YSHCN
    - Assisting with development of an Individualized Education Plan for YSHCN
    - Ensuring compliance with Section 504 of the Rehabilitation Act through modifications and alternate assessments for YSCHN
    - Collaborating with schools on Individual Transition Plans

- Hurricane Protection and Emergency Preparedness
  - Encouraging Pediatric and Family Practice physicians to complete AAP Emergency Information Form for Children with Special Needs as part of CC

Title V of the Social Security Act 701-710, subchapter V chapter VII, Title 42

MCHB Title V Grant #B04MC11257 (53% federal; 47% state match)

The MCH Title V Block Grant has six national performance measures (NPM's) focused on ensuring that CSHCN receive care in a MH, which is a "comprehensive, high quality, and cost effective approach to providing health care to children and youth, including CSHCN" (1) The six NPM's are:

1. Care is family centered.
2. CSHCN receive care in a comprehensive coordinated Medical Home (MH).
3. Children are screened early and continuously for SHCN.
4. Children have adequate health insurance.
5. Services are easy to use.
6. Youth receive all the services they need to transition successfully to adult work, healthcare and independence.[1]

NPMs are measured by the National CSHCN Survey, conducted every 5 years by CDC and MCHB. CSHS activities are designed to help LA meet these NPMs for families of CSHCN. LA has moved

from below the national average in all 6 in 2001 to above the national average in all but #3 and #6 in 2006. The newest activities in this APR target all 6 of these by improving MH capacity, focusing on CC and transition services, and most importantly, improving ease of use for families by improving interagency collaboration (2,3).

A growing body of research supports the MH model. In 2007, a joint statement on MH principles was developed and endorsed by the ACP, AAFP, AOA, and AAP (4). In 2008 Governor Jindal and DHH included the Patient Centered MH model as a core component of Medicaid reform. CSHS actively participates on the MH Committee of the LAHCQF, the AAP CSHCN Committee, and the CSHCN Heath Care Reform Workgroup.

CSHS has taken the lead in LA to promote CC and MH concepts by targeting academic pediatric and family practice clinics for CC and MH training. CSHS has developed a successful model for incorporation of CC into pediatric practices (5). Identifying an in-house care coordinator and giving incentives/TA to practices has been proven cost effective and efficient (6). Targeting teaching practices builds infrastructure for future pediatric practices.

Identification of training needs, provision of resource information and other TA to MHs can improve MH capacity in LA. Certification of MH through the National Committee for Quality Assurance (NCQA) is a way to identify model practices (7). By requiring application to be NCQA certified as a prerequisite to receiving CSHS incentives and training, CSHS can help MHs to achieve this goal.

CSHS's newly formed stakeholder group and participation in the DHH-DSS Data Integration Project directly target NPM #5 in making service entry more efficient for families and improving collaboration between programs.

1. www.medicalhomeinfo.org

2. www.aappolicy.aappublications.org. The American Academy of Pediatrics, Council on Children with Disabilities. Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for CSHCN. *Pediatrics* 2005 116: 1238-1244

3. **AAP Publications Reaffirmed and Retired, February and May 2008.** *Pediatrics* 2008 122: 450.

4. National Committee for Quality Assurance. *Physician Practice Connections – Patient-Centered Medical Home (PPC-PCMH).* Washington, DC: National Committee for Quality Assurance; 2008.

5. Susan Berry, M.D., MPH[1,3], Eleanor Soltau, BSN, CCM[2], Nicole E. Richmond, MPH[1,3], R Lyn Kieltyka, PHD[4], Tri Tran, MD, MPH[1,4], Arleen Williams, BSN, CCM[1,3] Effect of a Care Coordinator in Re-Establishing a Pediatric Medical Home in Post-Katrina New Orleans, publication pending.

6. Snow J. Care Coordination Final Report: Children with Special Health Care Needs Financing Initiative. Boston, MA: John Snow Inc; 2005.